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Nursing Care Satisfaction and Readiness for Hospital Discharge States of Patients Hospitalized in Internal Medicine Clinics: Descriptive Cross-sectional Research Example

Dahili Kliniklerde Yatan Hastaların Hemşirelik Bakım Memnuniyeti ve Taburculuğa Hazır Olma Durumları: Tanımlayıcı Kesitsel Araştırma Örneği

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ABSTRACT Objective: This descriptive and cross-sectional study was conducted to evaluate the nursing care satisfaction and readiness for hospital discharge of patients hospitalized in internal medicine clinics. **Material and Methods:** The universe of this study consisted of patients treated in the internal clinics of Atatürk University hospital between May and September 2019. The sample of the study, on the other hand, consisted of 372 patients aged 18 and over who did not have hearing, vision and mental problems, voluntarily accepted to participate in the study, had cognitive competence to answer the questions. The data were collected by using "personal information form", "Newcastle Nursing Care Satisfaction Scale", and "Readiness for Hospital Discharge Scale". **Results:** It was found that average age of the patients in the study was 58.7±17.5 years; 50.8% were male, 29.8% were illiterate, 90.6% were married, 78.5% had a moderate level of income, 59.4% were hospitalized from the outpatient clinics and 70.7% were very satisfied with nursing care. Average nursing care satisfaction of the patients was found to be 88.23±12.5. Readiness for hospital discharge total score of the patients was 6±1.99 and the highest score was taken from expected support sub-dimension (9.05±1.83), while the lowest score was taken from knowledge (4.18±4.15) sub-dimension. A statistically significant inverse relationship was found between the age and number of hospitalizations of the patients and the total score of the Readiness for Hospital Discharge Scale, personal care and coping skills sub-dimension scores ($p<0.05$). **Conclusion:** It was found that the patients had high nursing care satisfaction levels and that they were not sufficiently ready for discharge.

Keywords: Care satisfaction; nursing care satisfaction; patient; readiness for discharge

ÖZET Amaç: Bu çalışma, dahili kliniklerde yatan hastaların hemşirelik bakım memnuniyeti ve taburculuğa hazır olma durumlarının değerlendirilmesi amacıyla tanımlayıcı ve kesitsel olarak yapılmıştır. **Gereç ve Yöntemler:** Bu çalışmanın evrenini, Mayıs 2019 ve Eylül 2019 tarihleri arasında Atatürk Üniversitesi hastanesinin dahili kliniklerinde tedavi gören hastalar oluşturmuştur. Çalışmanın örneklemini ise işitme, görme ve zihinsel problemi bulunmayan, çalışmaya katılmayı gönüllü olarak kabul eden, soruları yanıtlayabilecek bilişsel yeterliliğe sahip, 18 yaş ve üzerinde olan 372 hasta oluşturmuştur. Veriler, "kişisel bilgi formu", "Newcastle Hemşirelik Bakımından Memnuniyet Ölçeği" ve "Taburcu Olmaya Hazır Olma Ölçeği" kullanılarak toplanmıştır. **Bulgular:** Çalışmaya katılan hastaların yaş ortalaması 58,7±17,5 olup, %50,8'inin erkek, %29,8'inin okuryazar olmadığı, %90,6'sının evli, %78,5'inin gelir düzeyinin orta olduğu, %59,4'ünün hastaneye polikliniken yatış yaptığı ve %70,7'sinin hemşirelik bakımından çok memnun oldukları saptanmıştır. Hastaların hemşirelik bakım memnuniyetinin 88,23±12,5 olduğu bulunmuştur. Hastaların taburculuğa hazır olma durumlarının toplam puanı 6±1,99 olup; en yüksek puanın beklenen destek (9,05±1,83) alt boyutundan, en düşük puanın ise bilgi (4,18±4,15) alt boyutundan alındığı saptanmıştır. Hastaların yaşı ve hastaneye yatış sayısı ile Taburcu Olmaya Hazır Olma Ölçeği toplam puanı, kişisel bakım ve baş etme becerisi alt boyut puanı arasında istatistiksel olarak önemli ters yönlü bir ilişki bulunmuştur ($p<0,05$). **Sonuç:** Hastaların, hemşirelik bakım memnuniyetinin yüksek olduğu ve taburculuğa yeteri kadar hazır olmadıkları bulunmuştur.

Anahtar Kelimeler: Bakım memnuniyeti; hemşirelik bakımı memnuniyeti; hasta; taburculuğa hazır olma

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The interest in patient satisfaction, which is a significant indicator of quality service in the field of health, has increased recently and become an indispensable part of the quality of care.[1-3] Patient satisfaction is a multi-dimensional concept which includes the presentation of service, the interaction of patients and service providers, the presence and continuity of service, the proficiency and communication characteristics of service providers. For this reason, patient satisfaction is accepted to be a result of health services.[3] The backbone of health services is nurses who are with the patient twenty-four hours of the day, who observe how the patient is affected by the patient's diagnosis and treatment procedures and the events experienced during these procedures most closely and who provide the coordination of the members of health team.[4,5] Nurses' being the decisive factor in the quality of care and patient care satisfaction is related with this specific position.[5] For this reason, patient satisfaction should regularly be evaluated by using valid and reliable measurement tools. Allowing the planning, evaluation and required arrangements in nursing care in line with the expectations of patients is very important in terms of finding deficiencies related with care and increasing the quality of nursing services.[5]

Increasing the quality of nursing care services enables patients to be more satisfied with the health care provided. It has been reported that in addition to being effective in developing patients' well-being and health, satisfaction in care is also effective in having a regular communication with health care providers and enabling patients' adaptation to treatment and being positively affected by their treatment.[2,6,7] For this reason, the quality of nursing care is very important in patients' perceiving satisfaction during the process from hospitalization to discharge.[8]

The concept of being ready for discharge is described as being ready to go home, in other words, as being ready to leave the hospital. In order to be able to tell the patients that they are ready to go home, they should have no questions or problems about their physical sufficiency, having the ability for self-care at home, presence of people who can look after them at home, reaching health care services when necessary and being discharged from hospital.[9-11]

It has been reported in literature that unnecessary stays in hospital can be decreased by sufficiently informing patients and families, anticipating the possible states of discharge and needs and taking the necessary precautions.[9] In addition, the process of discharge should be planned effectively so that positive results for clinical treatment can be obtained, problems about treatment and care after discharge can be solved and repetitive referrals to hospital and health expenses can be decreased.[9,12-14]

The planning of discharge training is important in all internal-surgical services; however, discharge training is more important in internal medicine clinics due to reasons such as long periods of hospitalization as a result of chronic illnesses and possible hospital infection. Internal medicine clinic patients should be informed about the source of problems, problem-oriented care, drug compliance, adaptation to changes in lifestyle, performing daily routines, problems after discharge and the ability to identify and solve these problems, doctor controls and routines, and the presence of closest health institutions and it is very important to give them training on discharge.[15]

It can be seen that patients who are not informed sufficiently and who are not prepared for discharge return to hospital with wrong treatment after discharge, anxiety and life-threatening complications.[10] Correct discharge training is the process of informing the patient for quality care which extends from hospitalization to post-discharge.[16]

Although there are a great number of studies examining the nursing care satisfaction of hospitalized patients in Turkey, there are few studies on nursing care satisfaction of patients hospitalized in internal clinics.[2,17,18] It was found that the state of being ready for hospital discharge was predominantly researched in postpartum mothers and that there were no studies examining its relationship with care satisfaction.[10,19] For these reasons, it was considered as a significant necessity to examine the nursing care satisfaction and states of being ready for discharge in patients hospitalized in internal medicine clinics. This study was conducted to evaluate the nursing care satisfaction and states of being ready for discharge in patients hospitalized in internal medicine clinics.

MATERIAL AND METHODS

RESEARCH SETTING AND CHARACTERISTICS

This descriptive and cross-sectional study was conducted to evaluate the nursing care satisfaction and readiness for hospital discharge in patients hospitalized in internal medicine clinics.

POPULATION AND SAMPLE OF THE STUDY

The population of the study consisted of patients treated in internal medicine clinics of Atatürk University hospital between May and September 2019. The sample of the study consisted of 372 patients aged 18 and older who did not have hearing, seeing and mental problems, who voluntarily agreed to participate in the study and who had the cognitive competence to answer the questions. In the literature review, total sample size was calculated as n=322 by using the G-POWER program with 0.3760 effect size, 95% power and 0.05 margin of error based on the percentage measurement values for the methods to be studied.[9] With the power analysis, 372 data collected were found to be sufficient.

DATA COLLECTION TOOLS

The data were filled in 10-15 minutes by the researchers in the patient room using face-to-face interview technique. Data were collected using the "personal information form", "Newcastle Nursing Care Satisfaction Scale", "Readiness for Hospital Discharge Short Form (RHDS-SF)".

Personal Information Form: This form, which was prepared by the researchers using related literature and studies, included 13 questions about the sociodemographic characteristics of the individuals.[1,2,9,10]

Newcastle Nursing Care Satisfaction Scale: The scale was developed by Thomas et al. in 1996 and it is used to assess the quality of nursing care in hospital. Turkish validity and reliability study of the scale was conducted by Uzun in 2003 and by Akin and Erdogan in 2007. The scale is a 5-Likert type scale consisting of 19 items including nursing care. The score is calculated as between 0 and 100 by adding up all the items and transforming them to 100. A total score of 100 means that the individual is satisfied with all the dimensions of nursing care.[20]

Readiness for Hospital Discharge Scale Short Form: Turkish validity and reliability of RHDS-SF, which was developed by Weiss et al. in 2014 to evaluate the readiness of patients for discharge, was conducted in 2018 by Kaya et al.[7,21] The scale consists of eight items and four dimensions and the items in the scale are evaluated on a scale between 0 and 100.[21] The dimensions of the scale are personal status of the patient, knowledge of the patient, coping ability of the patient and expected support of the patient. If the score of the dimensions is ≥7, the patient is evaluated as ready for discharge; if the score is <7, the patient is evaluated as not ready for discharge.[21,22]

ASSESSMENT OF DATA

The data were evaluated with SPSS 25 program. Normality of the data was evaluated according to skewness and kurtosis values (between -2 and +2) for numerical values. Parametric tests were used for the analysis of numerical data which were normally distributed; while non-parametric tests were used for the analysis of numerical data which were not normally distributed.[23] Non-parametric tests were used in this study because the data were not normally distributed. Mann-Whitney U test was used for analysis of paired independent variables and Kruskal-Wallis test was used for analysis of more than two variables. The level of significance was considered as 0.05 (p value) in statistical analyses.

ETHICAL PRINCIPALS OF THE STUDY

Approval was taken from the Ethical Board of the İstanbul Sabahattin Zaim University (21/03/2019 dated and 2019/03 numbered) and written permission was taken from the institution in which the study would be conducted. In addition, written and oral consent was taken from the participants after explaining the purpose of the study. Written permission was taken from the authors who conducted the validity and reliability studies of the scales. The study was conducted in accordance with the Declaration of Helsinki Principles.

RESULTS

Mean age of the patients who participated in the study was found as 58.7±17.5 years. It was found that 50.8% of the patients were male; 29.8% were illiterate; 90.6% were married; 78.5% had a moderate level

TABLE 1: Sociodemographic and clinical information of patients.

Variables	n (%)
Gender	
Female	183 (49.2)
Male	189 (50.8)
Level of education	
Illiterate	111 (29.8)
Primary	201 (54)
High school	39 (10.5)
University and higher	21 (5.6)
Marital status	
Married	337 (90.6)
Single	35 (9.4)
Working status	
Working	45 (12.1)
Not working	327 (87.9)
Social security	
Yes	249 (66.9)
No	123 (33.1)
Level of income	
Low	75 (20.2)
Moderate	292 (78.5)
High	5 (1.3)
Place of residence	
Village	102 (27.4)
Town	100 (26.9)
City	170 (45.7)
Referring unit	
Emergency	151 (40.6)
Polyclinic examination	221 (59.4)
Treatment unit	
Cardiology	90 (24.2)
Neurology	64 (17.2)
Nephrology	16 (4.3)
Chest diseases	46 (12.4)
Gastrology	31 (8.3)
Haematology	23 (6.2)
Oncology	53 (14.2)
Endocrinology	13 (5.1)
Dermatology	30 (8.1)
Presence of hospital attendant	
All the time	300 (80.6)
Sometimes	34 (9.1)
Never	38 (10.2)
Nursing care satisfaction	
Not satisfied at all	4 (1.1)
Somehow satisfied	6 (1.6)
Undecided	7 (1.9)
Satisfied	92 (24.7)
Very satisfied	263 (70.7)
Patients' perception of their overall health	
Perfect	11 (3)
Very good	25 (6.7)
Good	151 (40.6)
Not bad	128 (34.4)
Bad	57 (15.3)
Mean±SD	
Age	58.7±17.5
Number of hospitalizations	5.1±3.5
Length of hospitalization	8.7±12.1

SD: Standard deviation; Descriptive statistics were given as number (%) for categorical variables and as average and standard deviation for numerical variables; XX, Mean.

of income; 59.4% were hospitalized by being referred from the polyclinic and 70.7% were very satisfied with the nursing care (Table 1).

Mean Newcastle Nursing Care Satisfaction Scale score of the patients was found as 88.23±12.5, while mean RHDS-SF score of the patients was found as 6±1.99 (Table 2).

While a statistically significant, negative and weak association was found between the ages of the patients in the study and their RHDS-SF total score and personal status score; a significant, negative and moderate association was found between their age and coping ability score. While a statistically significant, negative and weak association was found between the number of hospitalizations and RHDS-SF total score and personal status and coping ability scores; a statistically significant, positive and weak association was found between the number of hospitalizations and knowledge scores. While a statistically significant, positive and weak association was found between the length of hospitalization of the patients and their personal status scores; a statistically significant, negative and weak association was found between the length of hospitalization and coping skills ($p<0.05$). No statistically significant association was found between nursing care satisfaction and readiness for hospital discharge. No significant and linear results were found in terms of the other correlations (Table 3, $p>0.05$ for each).

In this study, it was found that in terms of the type of being hospitalized, Newcastle Nursing Care Satisfaction Scale mean scores of the patients who were hospitalized from the emergency service were higher and the difference between was statistically significant ($X=89.7±12.4$, $p=0.016$); in terms of the unit patients were treated in, Newcastle Nursing Care Satisfaction Scale mean scores of the patients who were treated in endocrinology clinic were higher and the difference between was statistically significant ($X= 92.6±8.1$, $p=0.002$) and in terms of being satisfied with nursing care, Newcastle Nursing Care Satisfaction Scale mean scores of the patients who were very pleased with the nursing care were higher and the difference between was statistically significant ($X= 92.2±7.8$, $p=0.001$; $p<0,05$ for each). It was also found in the study that there were no significant differences between mean Newcastle Nursing Care Satisfaction

TABLE 2: Mean scores of Newcastle Nursing Care Satisfaction Scale total score, Readiness for Hospital Discharge Scale and sub-dimensions.

Scales	Minimum	Maximum	Mean±SD
Newcastle Nursing Care Satisfaction Scale	23.16	100	88.23±12.5
Readiness for Hospital Discharge Scale	0.13	10	6±1.99
Personal status	0	10	4.97±3.33
Knowledge	0	10	4.18±4.15
Coping ability	0	10	5.78±3.3
Expected support	0	10	9.05±1.83

SD: Standard deviation.

TABLE 3: Correlation between patients' age, number of hospitalization, length of hospitalization, Newcastle Nursing Care Satisfaction Scale, Readiness for Hospital Discharge Scale and sub-dimension scores.

Variables		Age	Number of hospitalizations	Length of hospitalization	Newcastle Nursing Care Satisfaction Scale
Newcastle Nursing Care Satisfaction Scale	r value	0.002	0.039	0.02	1
	p value	0.970	0.449	0.701	-
Personal status	r value	-0.176	-0.214	**0.109**	-0.031
	p value	**0.001***	**0.001***	**0.036***	0.552
Knowledge	r value	-0.053	0.112	0.025	0.005
	p value	0.311	**0.031***	0.629	0.919
Coping ability	r value	-0.402	-0.279	**-0.183**	-0.081
	p value	**0.001***	**0.001***	**0.001***	0.120
Expected support	r value	-0.02	-0.045	0.011	-0.032
	p value	0.699	0.385	0.836	0.535
Readiness for Hospital Discharge Scale	r value	-0.275	-0.159	-0.013	-0.041
	p value	**0.001***	**0.002***	0.804	0.427

*p<0.05; Spearman's correlation coefficient was used.

Scale scores in terms of gender, educational status, marital status, working status, social security status, level of education, place of residence, the state of having attendant and general health status (p>0.05).

It was found that male patients, those who had social security and those with very good general health status had significantly high RHDS-SF total score average. At the same time, it was found that patients who had university or a higher level of education had significantly higher RHDS-SF total score average than those who were illiterate; those who had moderate level of income had significantly higher RHDS-SF total score average than those who had low level of income and those who were living in a city or town had significantly higher RHDS-SF total score average than those who were living in a village (Table 4, p<0.05 for each).

In our study, RHDS-SF personal status sub-dimension score averages of the patients who were working and those who expressed their general health status as very good were significantly high. Knowledge sub-dimension score averages of the patients who were working and those who had social security were significantly higher. Single patients, male patients, high school graduates, working patients, patients with moderate level of income, those who were hospitalized by being referred from polyclinic, those who did not have attendants and those who had very good general health status were found to have significantly high coping ability score averages. Expected support sub-dimension average scores were found to be significantly higher in patients who were working and those who had attendants when compared with those who did not have attendants (Table 4, p<0.05 for each).

TABLE 4: Comparison of Readiness for Hospital Discharge Scale and sub-dimension scores in terms of sociodemographic and clinical information of patients.

		Personal status	Test	p value	Knowledge	Test	p value	Coping ability	Test	p value	Expected support	Test value	p value	Readiness Discharge Scale	Test	p
Gender**	Female	4.7±3.4	-1.676	0.094	4.2±4.2	-0.245	0.807	5.3±3.2	-3.306	**0.001***	8.9±2	-1.507	0.132	5.8±2	-2.360	0.018*
	Male	5.3±3.3			4.2±4.1			6.3±3.3			9.2±1.6			6.2±2		
Level of education***	Illiterate	4.5±3.2	5.988	0.112	3.9±4.1	4.623	0.202	4.6±3.2	34.658	**0.001***	9±1.7	3.613	0.306	5.5±1.9	20.038	0.001*
	Primary	5±3.4			4.1±4.1			6±3.3			8.9±2.1			6±2		
	High school	6.1±3			4.5±4.2			7.5±3			9.5±0.9			6.9±1.8		
	University and higher	5.1±3.2			6±4.5			7.4±2.8			9.6±0.9			7±2		
Marital status**	Married	4.9±3.3	-0.468	0.641	4.2±4.1	-0.282	0.779	5.7±3.3	-2.377	**0.018***	9.1±1.8	-0.620	0.536	6±2	-0.864	0.388
	Single	5.2±3.6			4±4.3			7±3			8.9±2.2			6.3±2.1		
Working status**	Working	6.2±3.5	-2.478	**0.013***	6±4.3	-2.957	**0.003***	7.7±3.1	-4.626	**0.001***	9.6±0.8	-2.043	**0.041***	7.4±2	-4.812	**0.001***
	Not working	4.8±3.3			3.9±4.1			5.5±3.3			9±1.9			5.8±1.9		
Social security**	Yes	5±3.4	-0.096	0.924	4.8±4.3	-3.587	**0.001***	5.9±3.4	-1.720	0.086	9.1±1.8	-0.846	0.398	6.2±2.1	-2.858	**0.004***
	No	5±3.2			3±3.7			5.5±3.1			8.9±2			5.6±1.7		
Level of income***	Low	4.4±3	2.764	0.251	3.1±3.8	4.746	0.093	5.3±3.2	9.820	**0.007***	8.8±2	1.274	0.529	5.4±1.8	10.125	**0.006***
	Moderate	5.1±3.4			4.5±4.2			6±3.3			9.1±1.8			6.2±2		
	High	4.2±3.3			4.3±5.2			2.2±2.3			9.8±0.5			5.1±2.6		
Place of residence***	Village	4.9±2.9	0.026	0.987	3.5±4	3.032	0.220	5.3±3.2	4.203	0.122	8.6±2.3	4.598	0.100	5.6±1.8	7.527	**0.023***
	Town	5±3.5			4.5±4.3			5.8±3.5			9.3±1.6			6.2±2.1		
	City	5±3.5			4.4±4.1			6±3.3			9.2±1.6			6.2±2.1		
Referring unit**	Emergency	4.8±3.3	-0.855	0.393	4±4.1	-0.779	0.436	5.3±3.5	-2.015	**0.044***	9.1±1.9	-1.308	0.191	5.8±1.9	-1.661	0.097
	Polyclinic examination	5.1±3.3			4.3±4.2			6.1±3.2			9±1.8			6.1±2		
Treatment unit***	Cardiology	5.4±3.4	13.844	0.086	5.6±4.1	29.308	**0.001***	6.8±2.6	20.067	**0.010***	9.2±1.8	37.186	**0.001***	6.7±1.7	33.399	**0.001***
	Neurology	5.4±3.3			4.4±4.3			5.3±3.9			9±2			6±2.2		
	Nephrology	3.7±3.3			2.5±3.7			3.9±3.8			9.6±0.8			4.9±1.6		
	Chest diseases	4.9±3.2			3.2±3.9			5.1±3.2			9.6±1.3			5.7±1.9		
	Gastrology	4±3.7			3.5±4			5.9±3.1			9.4±1.2			5.7±1.9		
	Haematology	5.7±3.5			4.4±4.6			6±3.2			8.9±1.5			6.2±2.2		
	Oncology	5.4±3.1			5±4.1			5.2±3.5			9.3±1.6			6.2±2.1		
	Endocrinology	3.8±3.5			2±2.8			5.1±3.2			7.1±2.9			4.5±2		
	Dermatology	4.1±2.6			2.1±3.4			6.9±2.7			8.3±2			5.4±1.4		
Presence of hospital attendant***	All the time	5±3.3	3.461	0.177	4.3±4.2	0.178	0.915	5.5±3.4	8.819	**0.012***	9.2±1.6	7.714	**0.021***	6±2	1.050	0.592
	Sometimes	5.7±3.4			4±4.1			6.7±2.6			8.8±2			6.3±2.1		
	Never	4.4±3.2			3.7±4			7.1±2.6			8±2.7			5.8±2.1		

continue →

TABLE 4: Comparison of Readiness for Hospital Discharge Scale and sub-dimension scores in terms of sociodemographic and clinical information of patients *(continued)*.

		Personal status	Test	p value	Knowledge	Test	p value	Coping ability	Test	p value	Expected support	Test value	p value	Readiness Discharge Scale	Test	p
Nursing care satisfaction***	Not satisfied at all	4.3±4.2	4.760	0.313	7.3±4.9	5.068	0.280	4.8±5.5	0.911	0.923	10±0	3.458	0.484	6.6±2.8	2.449	0.654
	Somehow satisfied	5.3±3.4			6.6±3.9			5.3±3.2			9.3±1.8			6.6±1.9		
	Undecided	3.9±2.5			2.3±3.1			4.9±4.5			9.4±1.1			5.1±2.3		
	Satisfied	5.6±3.2			4.1±4			5.6±3.4			9.1±1.7			6.1±2.1		
	Very satisfied	4.8±3.4			4.2±4.2			5.9±3.2			9±1.9			6±2		
Patients' perception of their overall health***	Perfect	5±3	44.635	**0.001***	2.3±3.2	8.955	0.062	4.6±3.7	29.382	**0.001**	8.8±1.3	8.755	0.068	5.2±1.8	44.676	**0.001***
	Very good	7±2.9			6.4±4.1			7.8±2.2			9.6±0.7			7.7±1.8		
	Good	5.7±3.2			4.2±4.2			6.4±3.1			9.2±1.7			6.4±1.9		
	Not bad	4.8±3.5			4.1±4.2			5.4±3.4			9.2±1.7			5.9±1.9		
	Bad	2.7±2.4			3.8±3.8			4.3±3.2			8.2±2.5			4.8±1.8		

*p<0.05; **Mann-Whitney U test was used; ***Kruskal-Wallis H test was used.

DISCUSSION

In this study, we evaluated the nursing care satisfaction and readiness for hospital discharge of patients in internal medicine clinics. Average nursing care satisfaction scores of the patients in internal medicine clinics was found as 88.23±12.5. Considering that the highest score one can get from nursing care satisfaction scale is 100, it can be said that the nursing care satisfaction of the patients in our study were high. Unlike our study, nursing care satisfaction of the patients in internal medicine clinics in studies conducted by Akin and Erdogan, Gekçil et al., Cerit and Yanık and Ateş were found to be moderate as 65.48±16.33, 62.21±22.32, 78.10±13.46 and 67.82±16.13, respectively.[18,20,24,25] It was thought that this difference may have resulted from the educational or socio-cultural characteristics of the participants or the differences in the service quality of the hospitals the studies were conducted in.

In our study, it was found that from which unit the patients were referred, the services they were hospitalized in and their states of being satisfied with nursing care had a statistically significant effect on their Newcastle Nursing Care Satisfaction Scale (Table 4; $p<0.05$). Unlike our study, Kayrakcı and Özşaker and Yanık and Ateş found that how the patients were hospitalized did not have a statistically significant effect on nursing care satisfaction.[18,26] In addition, while Yanık and Ateş found that patients' nursing care satisfaction was not significant in terms of the service they were hospitalized in, it was found in our study that the patients in endocrinology and haematology clinics had higher nursing care satisfaction.[18] Similar to the results of our study, a great number of studies in literature evaluating the nursing care satisfaction states of patients found that the patients stated that they were satisfied with the nursing services and care practices they received.[18,26]

Average total scores of the patients' readiness for hospital discharge was found as 6±1.99. Considering that a score of ≥7 is evaluated as the patient is ready for discharge, while <7 is evaluated as the patient is not ready, it can be said that the readiness for hospital discharge is not sufficient in our study. The highest score in our study was taken from expected support sub-dimension (9.05±1.83), while the lowest score was taken

from the knowledge sub-dimension (4.18±4.15). Similar to our study, in the Turkish validity and reliability study of the scale by Kaya et al., it was found that the highest score was taken from expected support sub-dimension (7.66±2.97) and personal status sub-dimension (7.69±2.24), while the lowest score was taken from the knowledge sub-dimension (6.62±3.41).[7] Similarly, in the study conducted in internal medicine clinics by Kaya et al., it was found that the patients felt ready for discharge in the sub-dimension of expected support at most, while they felt ready for discharge in the sub-dimension of knowledge at the least.[27] Unlike our study, in the studies of Weiss and Piacentine and Weiss et al. conducted in internal medicine and surgery clinics, it was found that the highest score was in coping ability sub-dimension, while the lowest score was in personal status sub-dimension.[28,29] In a study conducted on elderly patients by Coffey and McCharthy, the highest score was found in personal status sub-dimension (7.7±1.67), while the lowest score was found in expected support (6.8±2.85) sub-dimension.[30] This difference between studies conducted in foreign countries and in our country can be associated with Turkey's social structure. In addition, the reason for low scores in knowledge sub-dimension can be due to informing the patients insufficiently or due to patients' not being able to understand well the information given.

A statistically significant and negative association was found between the patients' ages and RHDS-SF total score, personal status and coping ability sub-dimension scores (Table 3; $p<0.05$). In a study they conducted on internal medicine clinics, Kaya et al., found that as age increased, the patients' possibility of being ready for discharge decreased.[27] Coffey and McCharthy found that when compared with patients younger than 80, patients older than 80 had lower readiness for hospital discharge total scores, knowledge and coping ability sub-dimension scores.[30] The results of studies conducted were found to be similar to the results of our study. It is possible that the fact that old individuals have to fight physical, mental and emotional problems and diseases difficult to treat can have caused old individuals to become dependent and in need of care and the emergence of these results.[31]

While there was a significant negative association between patients' number of hospitalization and their RHDS-SF scores and personal status and coping ability sub-dimension scores, a significant positive association was found between patients' number of hospitalization and their knowledge sub-dimension (Table 3; $p<0.05$). In line with these results, although the increase in the number of hospitalization shows that the patients are ready for discharge in terms of knowledge, this situation causes patients to be influenced physically, psychologically and socially and can have a negative influence on coping ability.

In our study, length of hospitalization influences patients' coping ability and as the number of hospitalization increases, the possibility of readiness for discharge decreases in terms of coping ability. Similar results were found in Kaya et al's study.[27] Since coping ability is associated with patients' personal status, it can be said that the patients who were not physically well and those who cannot manage their coping processes well are hospitalized for longer periods of time. However, it can be seen in our study that as the length of hospitalization increases, the possibility of readiness for discharge increases in terms of personal status. The reason for this can be the treatment and good care during this process.

In our study, it was concluded that there was no significant association between Newcastle Nursing Care Satisfaction Scale total score averages and RHDS-SF total and sub-dimension score averages. However, unlike our study, there are studies which report that real-time evaluation of readiness for hospital discharge is associated with patient care.[32,33] The reason of this difference in our study can be due to the fact that the number of sample was small.

In our study, it was found that gender had a significant effect on RHDS total score and coping ability and that it was higher in male patients (Table 4; $p<0.05$). In addition to studies which have parallel results with the results of our study, there are also studies in literature which concluded that gender does not have an effect on the readiness for discharge.[11,27,28,34] In line with these results, this difference can be due to the patriarchal structure of the region the study was conducted in.

The results of our study show that the patients' RHDS total score and coping ability sub-dimension were significantly affected as their level of education increased. Similar to the results of our study, it is reported in previous studies that patients with high level of education feel more ready for discharge.[11,21,27,28,30,33]

It was found in our study that marital status had a significant effect on coping ability and that single participants had higher scores (Table 5; $p<0.05$). Unlike our study, Kaya et al. found that married patients had higher coping ability.[27] This difference in our study can be resulting from the number of single patients.

It can be seen in our study that the working patients are more ready for discharge (Table 4; $p<0.05$). This result can bring to mind that working patients may have felt more ready due to their work responsibilities.

It can be seen in our study that having a good level of income had a significant influence on RHDS total score and coping ability sub-dimension (Table 4; $p<0.05$). Similar to the results of our study, there are a great number of studies which report that individual characteristics such as income level have an influence on readiness for hospital discharge.[11,21,28,33]

It was found in our study that the patients who lived in village were not more ready for discharge (Table 4; $p<0.05$). This result can be due to the fact that the patients living in village have more difficult access to hospital. In addition, it was found that the patients who were referred to hospital from emergency service did not feel ready for discharge in terms of the sub-dimension of coping ability. The reason for this can be fears of the patients who were hospitalized after referring to emergency that they may experience the same problems again.

When the patients' readiness for hospital discharge was evaluated in terms of hospital attendant, it was found that the patients who did not have attendants had higher coping ability sub-dimension scores, while they had lower expected support sub-dimension scores. The fact that the patients who do not have attendants have an active role in their own care can have a positive influence on their getting stronger for their care.[35] It is an expected situation that patients who do not have attendants do not feel ready for discharge in terms of expected support. In addition, it is an expected situation for those who perceive their general health as very good to have a higher possibility of discharge.

LIMITATIONS OF THE STUDY

This study is limited to patients hospitalized in internal medicine clinics of a university hospital.

CONCLUSION

It was found that the patients hospitalized in internal medicine clinics had higher nursing care satisfaction, while they felt insufficient about readiness for hospital discharge. The highest readiness for hospital discharge scores were found in expected support sub-dimension, while the lowest scores were found in knowledge sub-dimension. It was found that patients' age, number of hospitalization, length of hospitalization, gender, marital status, educational status, level of income, working status, the units they were treated in and how they perceived their general health status affected their readiness for discharge. It was found that the patients' type of hospitalization, the service they were hospitalized in and their states of being satisfied with nursing care affected nursing care satisfaction.

In line with these results, it can be recommended for nurses to personalize care by paying attention to patient characteristics and to prepare patients for discharge by training them about their needs, these trainings and care to be evaluated by health institutions within specific periods and thus to review the care given, the study to be conducted with larger sample groups in different institutions and different clinics in order to increase care satisfaction and readiness for discharge.

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Conflict of Interest

No conflicts of interest between the authors and / or family members of the scientific and medical committee members or members of the potential conflicts of interest, counseling, expertise, working conditions, share holding and similar situations in any firm.

Authorship Contributions

Idea/Concept: *Gülcan Bahçecioğlu Turan, Zülfünaz Özer;* ***Design:*** *Gülcan Bahçecioğlu Turan, Zülfünaz Özer;* ***Control/Supervision:*** *Gülcan Bahçecioğlu Turan;* ***Data Collection and/or Processing:*** *Gülcan Bahçecioğlu Turan, Zülfünaz Özer, Gülden Atan;* ***Analysis and/or Interpretation:*** *Gülcan Bahçecioğlu Turan, Zülfünaz Özer, Gülden Atan;* ***Literature Review:*** *Gülcan Bahçecioğlu Turan, Zülfünaz Özer, Gülden Atan;* ***Writing the Article:*** *Gülcan Bahçecioğlu Turan, Zülfünaz Özer, Gülden Atan;* ***Critical Review:*** *Gülcan Bahçecioğlu Turan, Zülfünaz Özer, Gülden Atan;* ***References and Fundings:*** *Gülcan Bahçecioğlu Turan, Zülfünaz Özer, Gülden Atan;* ***Materials:*** *Gülcan Bahçecioğlu Turan, Zülfünaz Özer, Gülden Atan.*

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